

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER The Timbers of Cass County		STREET ADDRESS, CITY, STATE, ZIP CODE 55432 Colby St Dowagiac, MI 49047	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999</p> <p>Based on interview, and record review, the facility failed to honor mealtime preferences for 3 anonymous residents (attending a resident council meeting) and Resident #78, resulting in expressed feelings of discontent and a potential for increased loneliness.</p> <p>Findings include:</p> <p>Resident #78</p> <p>Review of an Admission Record revealed Resident #78, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia (chronic condition in which blood flow to the brain is reduced causing impaired thinking, memory, and behavior), feeding difficulties, and major depressive disorder (serious mental health condition causing persistent low mood and loss of interests).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #78, with a reference date of 09/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #78 was severely cognitively impaired. Section GG of the MDS revealed Resident #78 required supervision, verbal cueing and/or touching assistance for eating. Review of a MDS with a reference date of 9/27/23, section F revealed Resident #78 indicated being around groups of people was very important to her.</p> <p>Review of a Care Plan for Resident # 78, with a reference date of 10/5/22, revealed a problem/goal/approaches of: Problem: Alteration in ADLs (activity of daily living) . Goal: (Resident #78) will . participate in cares to her fullest ability. Approaches: Eating: Assist per 1 .offer resident choice in bathing, clothing, bedtime, etc.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/29/24 at 1:10pm, Family Member/Durable Power of Attorney (FM/DPOA) YY reported Resident #78 had not been given the opportunity to eat her evening meals or any weekend meals in the dining room for many months. FM/DPOA YY reported she visited Resident #78 daily in effort to provide the resident with socialization and support with eating. FM/DPOA YY reported she told the facility it was important for Resident #78 to eat all her meals in the communal dining room but was told the facility could not support this preference due to staffing concerns. FM/DPOA YY reported Resident #78 sat in her room most of the day unless she went to the dining room for her meals. FM/DPOA YY reported socialization was important to Resident #78 because she enjoyed being around people. FM/DPOA YY reported going to the dining room was also beneficial for Resident #78 because the setting cued her to initiate feeding herself.</p> <p>In an interview on 10/31/24 at 12:01pm, Certified Nursing Assistant (CNA) II reported the residents had not been given the option to eat their evening meals or any of the weekend meals in the dining room in nearly 2 years. CNA II reported she residents and family members complained several months ago about the resident having to eat their meals in their rooms, but nothing had changed. CNA II reported it was not always possible to ensure the residents had the assistance they needed for eating when they ate in their rooms.</p> <p>In an interview on 10/31/24 at 1:22pm, Director of Nursing (DON) B reported the facility opted to stop communal dining for the evening meal because of staffing issues. DON B reported he was not aware the residents were not being given the opportunity to eat any weekend meals in the dining room, and that it was important the residents were given an opportunity to gather for meals because some residents look forward to it. When further queried, DON B reported the facility was currently fully staffed but the dining restrictions had not been lifted.</p> <p>In a confidential meeting on 10/30/24 at 3:15pm, 4 of 9 resident reported they were frustrated that they were not able to eat in the dining room for their evening and weekend meals. The residents reported they enjoyed getting out of their rooms and socializing in the dining room during meals, and that they were more independent with feeding themselves when seated at a dining table. The residents reported the dining restrictions had been in place for several months.</p> <p>Review of a facility policy titled Self-Determination and Participation, with a reference date of 1/24, revealed: Policy: Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life.</p> <p>41982</p> <p>In an interview on 10/29/24 at 10:20 AM, Dietary Supervisor (DS) Z reported the dining rooms were closed for the evening meal and that all the residents at in their rooms at that time. DS Z reported it had been like that for a while and she was not sure why they were closed; she had just been told by management that they were to be closed.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on interview and record review, the facility failed to provide timely notification of exhaustion of Medicare Part A benefits in 1 (Resident #90) of 4 residents reviewed for beneficiary notification resulting in Resident #90 being unaware of changes in regard to financial liability, and frustration.</p> <p>Findings include:</p> <p>Resident #90</p> <p>Review of an Admission Record revealed Resident # 90 was originally admitted to the facility on [DATE] with pertinent diagnoses which included difficulty in walking.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #90, with a reference date of 10/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #90 was cognitively intact.</p> <p>During an interview on 10/29/24 at 11:41 AM, Resident #90 reported that she had just been informed by the facility that she did not have Medicare coverage, and that she could expect to receive a bill from the facility for an estimated amount of \$10,000. Resident #90 reported that this was the first time the facility had made her aware that she did not have coverage to pay for the services she was receiving. Resident #90 was upset and crying and reported that she did not know how she would ever be able to afford the bill.</p> <p>During an interview on 10/31/24 at 12:28 PM, Business Office Manager (BOM) D reported that Resident #90 was admitted to the facility on [DATE] with only 7 days remaining of Medicare Part A coverage. BOM D reported that Resident #90 should have been informed by the admissions team that she only had 7 days of coverage. BOM D did not know if Resident #90 had been made aware that she only had 7 days of Medicare Part A coverage remaining.</p> <p>During an interview on 10/31/24 at 12:33 PM, Admission Director (AD) E reported she was not aware when Resident #90 admitted that she had 7 days of Medicare Part A coverage remaining and had learned that Resident #90 was changed to private pay. AD E confirmed that she did not inform Resident #90 that she had 7 days of coverage remaining, and that the facility had not given Resident #90 notice that her benefits were ending.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/24 at 2:09 PM, MDS RN M reported that she was the staff member that discovered that Resident #90 had exhausted her Medicare Part A benefits on 10/25/24. MDS RN M confirmed that Resident #90 should have received notice from the facility that her Medicare Part A benefits were exhausted 3 days before Resident #90's benefits were ending, but that the facility had missed this. MDS RN M reported that she was the staff member that would provide the notices to residents and confirmed that she had missed this because she was not aware that Resident #90 did not have Medicare Part A benefits remaining. MDS RN M confirmed that the admission team had missed communicating this to MDS RN M. MDS RN M confirmed that she had calculated an estimate of pending costs for Resident #90 and reported that she had told Resident #90 the bill was estimated to be around \$10, 000.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on interview and record review, the facility failed to develop comprehensive care plans for 2 (Resident #53 and Resident #90) of 20 residents reviewed for care planning resulting in the potential for unmet medical, physical, mental, and psychosocial needs.</p> <p>Findings include:</p> <p>Resident #53</p> <p>Review of an Admission Record revealed Resident #53 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care.</p> <p>Review of Resident #53's Orders revealed, Empty left Nephrostomy (artificial opening in the skin to allow urine to drain from the kidney) bag every shift .</p> <p>Review of Resident #53's Care Plan revealed that Resident #53 did not have a care plan developed for his nephrostomy bag.</p> <p>During an interview on 10/31/24 at 12:16, MDS RN M reported that she was the staff member responsible for ensuring care plan orders were in place for residents. MDS RN M confirmed that Resident #53 did not have a care plan in place for his Nephrostomy bag, and this was missed.</p> <p>Resident #90</p> <p>Review of an Admission Record revealed Resident # 90 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes mellitus (a disease that results in too much sugar in the blood).</p> <p>Review of Resident #90 Orders indicated that Resident #90 had orders for Duloxetine (antidepressant medication), Eliquis (anticoagulant medication), and Olanzapine (antipsychotic medication).</p> <p>Review of Resident #90's Care Plan revealed that Resident #90 did not have a care plan developed for her diabetes diagnosis or anticoagulant and psychotropic medications.</p> <p>During an interview on 10/31/24 at 11:47 AM, MDS RN M reported that she was the staff member responsible for ensuring care plan orders were in place for residents. MDS RN M reported that Resident #90 should have had a care plan in place for her diabetes diagnosis, and use of anticoagulant and psychotropic medications and that this was missed.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received care in accordance with professional standards in 1 (Resident #353) of 3 residents reviewed for quality of care, resulting in Resident #353 having dysuria (pain with urination) for approximately 7 days and the potential for a decline in overall physical, mental and psychosocial well being.</p> <p>Findings include:</p> <p>Resident #353</p> <p>Review of an Admission Record revealed Resident #353 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care.</p> <p>Review of Resident #353's Progress Notes dated 10/24/24 and documented by Registered Nurse (RN) Q revealed, .This evening Res (Resident #353) c/o (complaint of) frequent urination, he thinks he has a UTI (urinary tract infection). Concerned placed in (provider notification) book .</p> <p>Review of Resident #353's Progress Notes dated 10/25/24 and documented by Nurse Practitioner (NP) SS revealed, . (Resident #353) is seen per his request today. He reports that he has increase in urinary frequency and burning with urination . consent for work for UTI .</p> <p>Review of Resident #353's Progress Notes dated 10/27/24 and documented by Nurse Practitioner (NP) SS revealed, .Pending urinalysis from previous visit .</p> <p>Review of Resident #353's Progress Notes dated 10/29/24 and documented by Registered Nurse (RN) Q revealed, .(Resident #353) c/o dysuria (pain with urination). NP (Nurse Practitioner) notified, ordered UA .</p> <p>During an interview and observation on 10/29/24 at 10:22 AM, Resident #353 reported that he had been experiencing pain with urination since 10/25/24 and he was waiting for the facility to obtain a urinalysis (UA) to determine a treatment for him.</p> <p>During an interview and observation on 10/30/24 at 10:59 AM, Resident #353 reported that he was still experiencing pain with urination. Resident #353 reported that the facility had taken a UA sample, but he still had not heard anything about it.</p> <p>During an interview on 10/31/24 at 12:39 PM RN Q reported that Resident #353 had reported discomfort with urination to her on 10/24/24 and that she wrote down the concern in the provider communication book for NP SS to review. RN Q reported that there was a delay with the facility obtaining a UA for Resident #353, but she did not know why.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/24 at 1:37 PM, NP SS reported that she had been made aware of Resident #353's concern about pain with urination on 10/24/24. NP SS reported that she had given a verbal order for a UA to Licensed Practical Nurse (LPN) U on 10/24/24. NP SS reported that she was able to place the order herself, but since she was busy, she asked LPN U to do this for her. NP SS reported that she followed up on 10/25/24 with RN Q and was informed that the UA had not been ordered by LPN U and that RN Q was not aware of the order. NP SS reported that she asked staff to place the order again. NP SS confirmed that the order was not placed until 10/29/24. NP SS confirmed that she had not yet reviewed the UA results for Resident #353. NP SS confirmed that she would expect that a resident complaining of pain with urination had a UA completed the same day. NP SS confirmed that Resident #353 had experienced a delay in care for his pain with urination due to the facility not placing an order for an obtaining a UA.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999</p> <p>Based on observation, interview, and record review, the facility failed to provide individualized activities based on resident preferences, needs, and abilities for 1 of 2 Residents (Resident #55) reviewed for activities, resulting in a potential for social isolation, decreased connectedness to the resident's environment, and decreased overall well-being.</p> <p>Findings include:</p> <p>Review of Activity Involvement and Quality of Life of People at Different Stages of Dementia in Long Term Care Facilities revealed: Despite resident's cognitive status, their activity involvement was significantly related to better scores on care relationship, positive affect, restless tense behavior, social relations . Conclusion: Activity involvement seems to a small yet important contributor to higher well-being in long-term care residents at all stages of dementia . [NAME] D, de [NAME] J, Willemse B, Twisk J, Pot AM. Aging Ment Health. 2016;20(1):100-9. doi: 10.1080/13607863.2015.1049116. Epub 2015 Jun 2. PMID: 26032736.</p> <p>Resident #55</p> <p>Review of an Admission Record revealed Resident #55, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia (chronic condition in which blood flow to the brain is reduced causing impaired thinking, memory, and behavior), and cognitive communication deficit.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #55, with a reference date of 7/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated Resident #55 was unable to complete the assessment. Section B of the MDS revealed Resident #55 was rarely/never understood. Section C of the MDS revealed Resident #55 had short- and long-term memory deficits, severely impaired decision-making skills, experienced continuous disorganized thoughts, and was not oriented to staff, the season, or her location. Review of an MDS dated [DATE], which reflected the last time Resident #55's Preferences for Customary Routines and Activities was assessed, revealed Resident #55 enjoyed listening to music, being around pets, and spending time in groups of people.</p> <p>Review of a Care Plan for Resident #55, with a reference date of 11/13/18, revealed a problem/goal/approaches of: Problem: (Resident #55) prefers activities that identify with prior lifestyle .enjoys listening to music, watching, tv, sitting in the day room and interacting with staff and other residents. Goal: (Resident #55) will not exhibit boredom/isolation as evidenced by: doing her own independent activities and groups as interested. Approaches: encourage resident to become involved in activities: socials, musical entertainment, special events .interview resident to determine prior interests .provide pet visits as available . provide occasional visits with resident.</p> <p>Review of an Activity Log for Resident #55 revealed the resident was documented as participating in movies/popcorn and 6 room visits for the month of September 2024. Review of Activity logs for Resident #55, with references dates of 4/24-9/24, revealed Resident #55 did not receive sensory stimulation activities for that 5-month period.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/31/24, at 1:14pm, Activity Assistant (AA) K reported she had about 45 minutes a day to offer room visits to residents who did not regularly attend group activities, and each visit lasted 10-15minutes. When further queried about the content of the room visits, AA KK stated We can only do so much. It's usually just talking.</p> <p>During an observation on 10/29/24 at 10:50am, Resident #55 sat in her wheelchair, flexed at the hips, with her eyes cast toward the floor. Her right index finger was in her mouth. No staff were present as Resident #55, and several other residents of like ability, sat alone in the day room. The residents did not interact with each other. The television was on nearby but Resident #55 did not appear aware of its presence. No music was available.</p> <p>During an observation on 10/30/24 at 9:01am, Resident #55 sat in her wheelchair in the day room area. Resident #55 sat flexed at the hips, with her head hung downward and rested on her right hand. Several other residents of like ability sat nearby, none of the residents interacted and no staff were present. The television was on nearby but Resident #55 did not appear aware of its presence. No music was available.</p> <p>During an observation on 10/30/24 at 11:04am, Resident #55 remained in the same location as previously observed on this day. Resident #55 moaned, held her head in her right hand with her eyes closed. No staff were present.</p> <p>During an observation on 10/31/24 at 9:54am, Resident #55 sat in her wheelchair in the day room. Resident #55 was flexed at the hips, alert, with her eyes cast toward the floor. She made incoherent vocalizations. The television was on but Resident #55 did not appear aware of its presence. No music was available.</p> <p>During an observation on 10/31/24 at 11:42am, Resident #55 sat in the same location as previously observed on this date. Resident #55 was alert with her eyes cast toward the floor as she gripped the collar of her shirt with her right hand. No staff were present.</p> <p>During an observation on 10/31/24 at 1:38pm, Resident #55 sat in her wheelchair in the day room with her eyes closed. No staff were present. No music was available.</p> <p>In an interview on 10/31/24 at 11:23am, Activities Director (AD) J reported residents who don't regularly attend group activities should get room visits 2-3 times a week to meet their social and leisure needs. AD J reported the activity staff provided sensory stimulation activities regularly for residents with severe cognitive impairments. AD J reported each unit had activity supplies for floor staff to provide to the residents, including sensory activities for those who were dependent on staff for assistance to participate in leisure activities, including Resident #55. AD J reported all resident activity participation was documented in the activity logs. When further queried about how staff knew what to leisure activities to assist residents with, AD J reported staff could ask her or use the resident's care plan to know what types of leisure supplies each resident needed/preferred.</p> <p>In an interview on 10/31/24 at 12:01pm, Certified Nursing Assistant (CNA) II reported the facility did not offer many activities for residents who had severe cognitive deficits. CNA II reported nursing staff were diligent about assisting residents with getting up each day, but there's nothing for them to do and they need things to do to maintain their abilities. CNA II reported each unit had coloring pages and a few sensory products for residents but she was not sure which residents used them.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384</p> <p>This intake pertains to intake MI00146328.</p> <p>Based on observation, interview, and record review, the facility failed to prevent elopement for 1 (R82) of 6 residents reviewed for elopement, resulting in R82 leaving the facility alone, unbeknownst to staff, for an extended period, and was later found under a bush next to the facility resulting in potential for further successful elopements.</p> <p>Findings include:</p> <p>Review of facility policy, Elopement Prevention and Management Program reviewed 01/2024, revealed, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .Wandering is random or repetitive locomotion that may be goal-directed (appears to be searching for something such as an exit) . Elopement occurs when a resident leaves the premises or a safe area without authorization .Alarms are not a replacement for necessary supervision .The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering including identification and assessment of risk .implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary .Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff .Adequate supervision will be provided to help prevent accidents or elopements .Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly .</p> <p>According to the Minimum Data Set (MDS) dated [DATE], R82 scored 10/15 (moderately cognitively impaired) on his BIMS (Brief Interview Mental Status), physically requiring substantial/maximal assistance with the helper doing more than half the effort. The resident had no impairment in his arms. Diagnoses included debility, cardiorespiratory conditions, and dens fracture type II (also known as a type II odontoid fracture, is a break in the base of the dens, the bony projection from the second neck bone, C2 and are considered unstable due to their high rate of non-union. They are most common in the elderly due to an increased risk of falls and decreased bone mineral density. Risk factors include trauma such as a fall. Conservative management includes immobilization in a cervical collar or halo vest). It was noted the resident lived on the Dogwood Unit (400-Hall).</p> <p>Review of R82's admission Elopement Risk assessment dated [DATE], indicated the resident had a history of elopement, was physically capable of eloping out of the facility by walking or using an assistive device such as a wheelchair, and verbalized the desire to leave the facility and/or return home. The resident was searching for his spouse or family.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R82's Elopement Risk assessment dated [DATE], indicated the resident was physically capable of eloping out of the facility by waking or using as assistive device such as a wheelchair, did NOT have a history of elopement, and verbalized the desire to leave the facility and/or return home while searching for spouse or family. It was noted, R82 left the building unattended and unnoticed on 8/5/2024.</p> <p>Review of R82's Elopement Risk assessment dated [DATE], indicated the resident was physically capable of eloping out of the facility by walking or using an assistive device such as a wheelchair, did have a history of elopement, did not verbalize the desire to leave the facility or return home to search for spouse or family.</p> <p>Review of R82's Order Summary, dated from 6/21/24 to 10/31/24, there were no orders for 1:1 observation, 15-minute checks, hourly checks, or Elopement Risk Precautions.</p> <p>Review of R82's Care Plan dated 8/5/2024 revealed a focus of At risk for elopement due to exit seeking. The goal for the resident was to not leave building unattended. Interventions to meet the goal included elopement risk assessment upon admit, quarterly, and PRN (as needed), resident to be on 1:1 (8/5/24), 8/6/24 15-minute checks, and 8/7/24 hourly checks. It was noted the intervention to meet the goal were not initiated until after the resident had left the building unattended and unnoticed on 8/5/2024.</p> <p>During an interview on 10/29/24 at 9:36 AM, Receptionist E stated, There is someone at the front desk from 8:30 AM -5 PM Monday through Friday. There is no one at the front desk after 5 PM. Someone is at the front desk Saturday and Sunday from 9 AM to 5 PM.</p> <p>Observed on 10/29/24 at 9:48 AM, the front entrance of the facility had two-sets of doors and a vestibule in between them. The doors leading into the facility front lobby had a 15-second alarm sign with the alarm controlled by magnets. Resident units were separated from the front lobby by a set of French doors. At the end of a short hallway leading away from the French doors was a hall that intersected named Apple Lane (100 Hall). To the right was a hall with resident rooms that went to a 2-way intersection meeting at a nurse station, Cedar Court (300-hall), Birch Street (200-hall) with activities and dining at the other end. To the left of the French door lobby was the remaining resident rooms of Apple Lane meeting at a nurse station intersection of Dogwood Trail (400-hall) to the left and Evergreen (500-hall) to the right. At the intersection of Evergreen and [NAME] (600-hall) was a nursing station with [NAME] leading the Service hall and Main dining room.</p> <p>Observed on 10/29/24 at 11:03 AM, R82 was on the 400-hall looking out the exit door while wearing a neck brace self-ambulating in a wheelchair.</p> <p>During an observation and interview on 10/29/24 12:01 PM, R82 was not in his room. Licensed Practical Nurse (LPN) TT stated, (R82) likes to wheel around on his own. I'm looking for him now to put eyes on him and document in the Elopement book. He needs to be documented on every hour. I've not seen him since the last time I documented on him at 11 am. LPN TT' walked from the Dogwood nursing station to the other side of the facility where she found R82 in the main dining room preparing to eat lunch.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/24 at 10:53 AM, Registered Nurse (RN) S stated, I work nights at the facility and was (R82's) nurse the night (8/5/24) he walked out of the building. There was a nurse on Evergreen Hall and Birch Hall. Around 5:20 AM (R82) was in his room. He was delaying my med (medication) pass that morning because he had been exit seeking most of the night. While he was in his room still in his wheelchair, I went to the next resident's room to do a lengthy med pass and he snuck past me while I was working with that resident. The door was shut. When I came out of the room, I went to the med cart, on Dogwood, to get (R82's) meds and noticed he was not in his room. It alerted me, Oh God, where did he go? I went to all the nurses in the building. I went to the Birch nurse first; I was told he was just there, but I did not see him. I got a CNA (Certified Nursing Assistant) and we went to look for him from Birch to Apple to the front. The French doors were closed. No noise was coming from them. The only way I was alerted that (R82) might have left the building was we heard the front door alarm and he might have went out the main entrance. It was pitch dark outside. This was about 5:30 AM. I was scared to death with the highway and river 1/2 mile up the road. (R82) had followed the sidewalk to the other side of the 200- hall wing. He was trucking, (going fast) and it was dark. He turned the corner, and the sidewalk ended. He fell out of the wheelchair onto the grass. His wheelchair was behind him. He had his neck brace on. He has an injury to his neck and could be paralyzed if does not wear it. He was dressed in street clothes with shoes. He does not like to go to bed when you want him to. Sometimes its 3 or 4 AM before he goes to bed. He was not on hourly checks at the time he left the building. At that time, he'd be up for 2 days and exit-seeking on and off. The only reason he got away from me I was in another resident's room. He could read and he read it takes 15 seconds to open the front door and he went out it. He is smart enough to read in the moment, but he cannot tell you what he ate 10 minutes before. The front door alarm was a quiet alarm and no one heard it back on the units. Every resident has the right to go where they want in the facility. At night there is only a couple of staff on the units. When you are in a resident's room, you cannot keep an eye on (R82). That night the CNAs were doing rounds and just could not keep an eye on (R82). It was only 10 minutes; it was 1 time in 10,000 that a resident got away from me. It still scares me that he could get away again. Instead of going back to Birch he went out to the lobby, through the French doors and out the two sets of front doors. The alarm could not be heard. He went as far sidewalk. If the sidewalk kept going he would have kept going. But the wheelchair stopped, and he fell out.</p> <p>During an interview on 10/30/24 at 11:31 AM CNA JJ stated, I work nights. I was the person that found (R82) on August 5th (2024). He had been looking all night for a way out of the building. I worked on another hall and would see him going to exit doors. He was also looking all day the day before trying to get out. On 3rd shift there are not many people to look out for him. The alarm from the front door could not be heard. The French doors were closed that night and staff could not hear the alarm from the front door. On that night, August 5, staff on Dogwood unit started the search for (R82) then came to ask me to find him along with the Dogwood nurse, a few CNAs, and a couple of first shift nurses. I found (R82) by myself by under a tree face down on the grass. He was towards the exit door to the right under the bushes. His wheelchair was next to him. It looked like he tried to walk in the grass and fell a couple of feet away from the wheelchair. It was dark outside with no lights on where he was out. He was awake. He was upset at me when I grabbed him and put him in the wheelchair. I did not know if he was passed out or broke anything when he fell. He wears a neck brace, and I did not know if he was hurt. I just hurried up and got him and put him back in his wheelchair. The other staff was searching in other areas and did not see him. It was hard to see him because it was so dark. I found him sometime after 5:30 AM. I think he went missing sometime after 5:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/24 at 12:15 PM, Nursing Home Administrator (NHA) A stated, We (the facility) do feel there is a citation for identifying him as an elopement risk in June 2024 and nothing was implemented to prevent elopement that evening and he still got out. Thankfully, the nurse must have increased supervision as she had her med cart at his door, saw him, prepped meds, and went to deliver those meds and when she came back noted he was gone. Then the search began, alarms were sounding, and he was found.</p> <p>During an observation and interview on 10/30/24 12:54 PM with Maintenance DD, the 15-second front door alarm was initiated. Maintenance DD stated, No new alarms have been put on the front door. Corporate approved the alarms two weeks ago, finally, and now the facility is waiting for the alarm company to schedule to install. The current alarm on the front door cannot be heard past the French doors that separate the lobby and resident areas. The French doors are closed every day after 5 pm. When the resident (R82) eloped in August (2024), I bought a Chirper alarm and put it on the French door. When the receptionist leaves at 5 pm, they close the French doors and turn on the Chirper alarm. There is no alternate sounding device installed at the front door, only sounds at the magnet situated on the door.</p> <p>Review of Battery Magnetic Door Alarm provided by Maintenance DD on 10/31/2024, indicated the environmental conditions of sound emission at 120 dB (dB (decibel) is a logarithmic unit used to measure sound level) which can be heard from 3.5 feet away.</p> <p>During an observation and interview on 10/30/24 at 1:08 PM, while exit door alarms were being tested , LPN X stated, I cannot hear the front door alarm, from the 500-halls, or the 200 nursing station. I've never heard the Chirper alarm. The Chirper had been initiated and could not be hear from the LPN or Surveyor at the 200-Hall nursing station, the closest station to the lobby, front door, and French doors. If (R82) is self-ambulating on my unit, I take him back to his unit. That is what staff have always done.</p> <p>During an observation, interview, and record review on 10/31/24 at 10:15 AM, LPN W stated while reviewing R82's documents in an Elopement book, (R82) is to be on one-hour checks and with documentation here. (R82) eloped a few months ago and he needs to be monitored. This monitoring was started after he left the building. Elopement risk assessments are done as needed and I think quarterly. He was an elopement risk before he eloped, but checks were not done on him at that time.</p> <p>Review of R82's Progress Notes indicated the resident had been exit seeking and behavioral tracking as indicated, dated:</p> <p>-6/23/24 at 2:20 PM, indicated the resident was alert and oriented to person, place, and time and was observed propelling his wheelchair in hallway with no difficulty.</p> <p>-6/24/24 at 3:21 AM, indicated the resident had been sitting up in his wheelchair self-propelling around his unit refusing to go to bed stating it was morning.</p> <p>-6/25/24 at 4:48 AM, indicated the resident was on behavioral tracking with some documented behaviors noted.</p> <p>- 6/26/24 at 6:25 AM, indicated the resident was independent with bed mobility, transfers, and propelling self in wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-6/27/24 at 9:45 AM, indicated the resident was admitted to the facility on [DATE] with diagnoses of dementia and healing fractures from recent falls.</p> <p>-6/29/24 at 2:40 PM, indicated the resident sleeps for a short period of time throughout day/night.</p> <p>-7/11/24 at 9:41 PM, indicated the resident was up later in the evening socializing with other residents.</p> <p>-7/14/24 at 9:00 PM, indicated the resident continues to self-transfer to/from bed/wheelchair without asking or waiting on assistance.</p> <p>-7/16/24 at 6:36 AM, indicated the resident was pleasantly confused, trying to elope twice on the night shift through two different unit's exit doors. Propelling self-ad lib in hallways. It was noted there were no interventions in R82's Care Plan to provide elopement safety interventions.</p> <p>-7/18/24 at 4:36 AM, indicated the resident had been up in his wheelchair the first few hours of the night shift wheeling self about the facility until 2 AM when he went to bed. At about 3:30 AM he was found in another resident's bed.</p> <p>-7/21/24 at 5:58 AM, indicated the resident had not gone to bed during the night shift and had been up in a wheelchair wheeling self about the facility all night.</p> <p>-7/24/24 at 2:34 AM, indicated the resident had been sitting all night in his wheelchair until 2:30 AM.</p> <p>-7/25/24 at 2:01 PM, indicated the resident was visiting different nurse stations while self-propelling in a wheelchair.</p> <p>-7/26/24 at 12:56 PM, indicated the resident verbalized he experienced someone running down the hallway with a dog and wanting to go home. Stated he did not understand how he got to this place because he just went out that morning for breakfast.</p> <p>-7/27/24 at 8:41 PM, indicated the resident was argumentative and confused with family explaining this was usual behavior after a seizure for a few days. Frequent checks were implemented related to the increased confusion as well as the resident sitting at closed doors. Resident was stating his girlfriend is here, his wife has my car and further stating he needed to get to the parking lot to find his care. Resident refused medication poison. It was noted frequent checks were no defined in the resident's Care Plan nor were they ordered.</p> <p>-7/29/24 at 7:25 AM, indicated the resident was exit seeking the entire night shift refusing to go to bed. It was noted there was no resident-specific treatment plan in the resident's Care Plan.</p> <p>-7/30/24, indicated the resident became agitated and argumentative with concerns that someone had stolen my pistol. Roommate reported R82 was rummaging in his drawers looking for a gun. Staff moved R82 to a private room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-8/2/24 at 2:29 AM, indicated the resident complained of being exhausted and not wanting to go to bed. He had been self-propelling around the facility in his wheelchair and at times walking while leaving his wheelchair in the hallway.</p> <p>-8/5/24 indicated the resident was unable to provide accurate information and denied going outside stating he had been in room sleeping. Resident was placed on 1:1 and placed in the elopement book. Care Plans and elopement assessment was completed. It was noted there was no resident-specific interventions placed in the resident's Care Plan prior to this incident.</p> <p>-LATE ENTRY 8/7/24 at 10:40 AM, indicated the resident was on 15-minute checks from 1:1 and continued behavioral tracking. It was noted there was no resident-specific interventions placed in the resident's Care Plan.</p> <p>-8/6/24 at 4:15 PM, indicated the IDT (interdisciplinary team) reviewed R82's incident and changed the resident's level of supervision from 1:1 to his whereabouts every 15 minutes. It was noted there was no resident-specific interventions placed in the resident's Care Plan.</p> <p>-8/7/24 at 4:48 PM, indicated the resident was on hourly checks from 15-minute checks. It was noted there was no resident-specific interventions placed in the resident's Care Plan.</p> <p>-8/7/24 at 8:35 PM, indicated the resident continued 15-minute checks. It was noted at 4:48 PM on 8/7/24 the resident's Progress Note indicated the resident was on hourly checks and no resident-specific interventions placed in the resident's Care Plan.</p> <p>-8/8/24 at 5:48 AM, indicated the resident remained on 15-minute checks. It was noted there was no resident-specific interventions placed in the resident's Care Plan.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637</p> <p>Based on observation, interview and record review, the facility failed to ensure timely and consistent weight monitoring for one resident (Resident #76) of 4 residents reviewed for nutritional status resulting in undetected weight loss, nutritional status decline and unmet nutritional needs.</p> <p>Findings include:</p> <p>Resident #76 (R76)</p> <p>Review of the Facesheet and Minimum Data Set (MDS) dated [DATE] revealed R76 admitted to the facility on [DATE] with diagnoses including cerebral infarction with right side hemiplegia and hemiparesis (stroke with right side weakness) and dysphagia (difficulty swallowing). A Brief Interview for Mental Status (BIMS) was not completed due to R76 having severe cognitive impairment.</p> <p>On 10/29/2024 at 2:15 PM, R76 was observed to be lying in bed and looked thin. He was unable to respond to questions.</p> <p>Review of R76's weight record revealed the following weights:</p> <p>10/20/2024: 121.4 lbs. (pounds)</p> <p>10/09/2024: 120.6 lbs.</p> <p>09/13/2024: 126.0 lbs.</p> <p>08/26/2024: 144.6 lbs.</p> <p>08/12/2024: 139.4 lbs.</p> <p>The weight on 9/13/2024 was recorded by Dietary Supervisor (DS) Z and the weight on 10/9/2024 was recorded by Registered Dietitian (RD) Y.</p> <p>The weights from 8/26/2024 to 9/13/2024 revealed a 12.8 percent weight loss.</p> <p>Review of the Initial Nutritional assessment dated [DATE] completed by RD Y revealed (R76) continues on his Mechanical Soft + (plus) Large Portions diet that he eats 75-100% (percent) most of the time. His BMI (body mass index) is 21.35 which is normal weight He is already receiving Magic Cup BID (twice a day) with lunch and dinner. There are no concerns/changes at this time.</p> <p>Review of the Quarterly Dietary Review assessment dated [DATE] completed by RD Y revealed (R76) continues on a Mechanical Soft diet that he eats with assistance and eats 75-100% of his meals. His BMI is 18.6 which is normal weight. He had gone to the hospital and when he returned his weight was within range but his next weight was 18# lower than his return weight. Believe it is wrong unless he had a bout with COVID which would affect his meal intake. Will continue to monitor until his new weight is done, then will re-evaluate.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Readmission Nutrition Assessment progress note dated 10/21/2024 completed by RD Y revealed (R76) continues on a Mechanical Soft diet which he is eating at this time 25-50% of his meals. His BMI is 18.45 which is underweight with mild thinness .</p> <p>On 10/30/2024 at 9:34 AM, it was observed that R76 was assisted with his meal in his room and he ate 25% of his breakfast tray.</p> <p>During an interview on 10/30/2024 at 4:31 PM, RD Y stated that she is at the facility one day a month and when she is offsite and notices a weight that is off she calls DM Z and asks her to put the resident on weekly weights.</p> <p>During an interview on 10/30/2024 at 4:38 PM, when asked about the significant change in weight from 8/26/2024 to 9/13/2024 and if a reweight was requested, DM Z stated that she put R76 on the weekly weight sheet that went out to the shower aides on 9/20/2024. She said she did not get the sheet back from them. DM Z acknowledged that the next weight obtained was on 10/9/2024 since a weight was not obtained for the next two weeks after that and she did not follow up on it. DM Z stated that she gets resident preferences but did not attempt to get R76's food preferences again after the weight change.</p> <p>During an interview on 10/31/2024 at 9:18 AM, Minimum Data Set Registered Nurse (MDS) N stated that since there was a significant change in weight on 9/13/2024, a reweight should have been done right away. MDS N noticed that it wasn't done until later.</p> <p>During another interview on 10/31/2024 at 11:23 AM, DM Z stated that she didn't notice the 9/13/2024 weight right away and told someone to get a reweight and she did not follow up on not receiving the weight.</p> <p>During another interview on 10/31/2024 at 11:33 AM, RD Y stated that they have weekly SOC (standards of care) meetings with the interdisciplinary team (IDT) where they discuss significant changes in weight but she does not attend the meetings. DM Z stated that she hasn't been able to attend the weekly SOC meetings many times. RD Y and DM Z reported that they did not follow up with the Director of Nursing (DON) when they didn't receive requested weights.</p> <p>During an interview on 10/31/2024 at 1:27 PM, Nurse Practitioner (NP) SS stated that she did not see R76 for weight loss since she wasn't aware of it. NP SS said that the DM doesn't talk to her about any weight concerns.</p> <p>During an interview on 10/31/2024 at 1:38 PM, DON B stated that he was only made aware of R76's weight loss the day before. When asked about the weekly SOC meetings, DON B said R76's weight loss wasn't brought up since RD Y doesn't attend them and DM Z attends sometimes. DON B said he was not aware that RD Y and DM 'Z weren't receiving requested weights. He stated that he prints the SOC agenda every week before the meeting and the weight area of the report is always blank.</p> <p>Review of R76's nutrition care plan under approach revealed notify Dr. (doctor) of significant change.</p> <p>(continued on next page)</p>		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Review of the Weight Monitoring Policy with a review date of 1/2024 revealed 4. Procedure: Residents will be weighed monthly in a timely manner (at least by the 10th of each month). Those residents that trigger for a significant weight loss (>5%) from the previous month will be placed on weekly weights. Each resident will be reviewed by the IDT committee and appropriate interventions will be put into place. Prior to the end of each month, the facility RD/CDM (certified dietary manager)/RDT (registered dietetic technician) will provide the DON a list of those residents identified and tracked; which residents re-gained the weight and those residents who continue to lose weigh. RD/CDM/RDT must document on weight gains and losses of those residents that experience 5% for 30 days 7.5% for 90 days and 10% for 180 days in the medical record to meet the professional standards for Dietitians. Nursing services is responsible to obtain monthly weights on each resident. Weekly weights will be obtained as indicated. The results are given to the DON, designee or RD/CDM/RDT for input into the computer. A weight report will then be printed indicating the following weight variances: Weight Variances Report for both weight loss and weight gain of 2 % in 1 week, 5 % in 1 month, 7.5 % in 3 months, 10 % in 6 months If a re-weigh is required it should be conducted in the presence of a licensed nurse and the weight recorded with the nurse's initials in the medical record, re-weights should be done within 48 hours of request. Notify MD of significant weight loss of 5%, 7.5%, 10%and Notify Resident Representative The DTR/RD is responsible for reviewing each resident that triggers on the weight variance report, making appropriate interventions and documenting in the medical record. The DTR/RD will discuss each resident with the weight committee, reviewing the interventions recommended, and any additional recommendations from the IDT. Weekly weights will be completed and given to the MDS Coordinator, or designee. The MDS Coordinator or designee will then print a weekly report and give a copy to the DTR/RD and DON. The report will show all residents on weekly weights and the percentage/pounds of weight change from week to week. The DTR/RD will be responsible for reviewing the weight variance report, making additional nutritional recommendations, documenting in the medical record and discussing the weight changes with the weight committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER The Timbers of Cass County		STREET ADDRESS, CITY, STATE, ZIP CODE 55432 Colby St Dowagiac, MI 49047	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>41982</p> <p>Based on interview and record review, the facility failed to provide documentation of education to the resident/representative on the intended or actual benefit versus potential risk(s) or adverse consequences associated with a psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) for 1 (Resident #35) of 5 residents reviewed for unnecessary medications, resulting in the potential for lack of awareness of medication risks versus benefits.</p> <p>Findings include:</p> <p>Resident #35</p> <p>Review of an Admission Record revealed Resident #35 was a female, with pertinent diagnoses which included: dementia in other diseases classified elsewhere, moderate, with mood disturbance; adjustment disorder with depressed mood; and major depressive disorder, recurrent, unspecified.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #35, with a reference date of 8/30/24 revealed a Brief Interview for Mental Status (BIMS) score of 6, out of a total possible score of 15, which indicated Resident #35 was severely cognitively impaired.</p> <p>Review of a Physician's Order for Resident #35 revealed, mirtazapine (an antidepressant, psychotropic medication) tablet; 30 mg (milligrams); amt (amount): 1tab (tablet); oral Special Instructions: Depression Once A Day Prior to Bed (PB) Start Date 03/15/2024</p> <p>Review of a Physician's Order for Resident #35 revealed, Zoloft (sertraline) (an antidepressant, psychotropic medication) tablet; 50 mg; amt: 50 mg; oral Special Instructions: Depression Once A Day Prior to Bed (PB) Start Date 08/25/2023</p> <p>Review of a Physician's Order for Resident #35 revealed, Seroquel (quetiapine) (an antipsychotic, psychotropic medication) tablet; 25 mg; amt: 1 tablet; oral Once A Day Prior to Bed (PB) 06/03/2024</p> <p>A review of Resident #35's medical record was conducted on 10/31/24 at approximately 9:00 AM for documentation that the resident/representative had been provided with education on the intended or actual benefit versus potential risk(s) or adverse consequences associated with Residents #35's psychotropic medications. A psychoactive medication consent form signed by Resident #35 and dated 8/25/23 for the antipsychotic medication Seroquel was located. There was no documentation of education for the prescribed antidepressants Mirtazapine or Zoloft located.</p> <p>In an interview on 10/31/24 at 9:15 AM, Social Services Director (SSD) H was requested to provide evidence that Resident #35/representative received education of the risks versus benefits of her prescribed antidepressant medications. SSD H reported she had been trained that a consent form was only required for the antipsychotic medication.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Timbers of Cass County		STREET ADDRESS, CITY, STATE, ZIP CODE 55432 Colby St Dowagiac, MI 49047	

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow-up interview on 10/31/24 at 10:12 AM, SSD H reported that the facility reviews the black box warnings (a warning issued by the Food and Drug Administration for drugs that carry specific health risk or adverse effects) with a resident/representative when a psychotropic medication was started but was not sure that was documented. During the interview, SSD H reviewed Resident #35's medical record for documentation of said reviews with resident/representative and reported she could not locate any at that time. At the conclusion of the interview, this surveyor encouraged SSD H to provide additional documentation as evidence that the resident/representative was adequately informed of the risks versus benefits of the antidepressant medications Resident #35 was prescribed prior to survey exit. No such documentation was provided by SSD H prior to survey exit on 10/31/24 at 4:00 PM.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' food preferences at meals were consistently honored for 2 (Residents #27 and #78) of 18 residents reviewed for food concerns resulting in resident/representative complaints of food choices not being honored and the potential for decreased meal enjoyment, feelings of frustration, and the potential for weight loss and nutritional decline.</p> <p>Findings include:</p> <p>Resident #27</p> <p>Review of an Admission Record revealed Resident #27 was a female, with pertinent diagnoses which included: generalized anxiety disorder, long-term (current) use of oral hypoglycemic (low blood sugar) drugs, depression, and type 2 diabetes mellitus (a condition where the body is not able to properly use sugar from the blood).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #27, with a reference date of 10/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #27 was cognitively intact.</p> <p>In an interview on 10/29/24 at 11:36 AM, Resident #27 reported she didn't consistently receive what she ordered on her meal trays. Resident #27 reported there had been times that she hadn't said anything to anyone about it because then she would have had to wait too long for the correct food to be delivered.</p> <p>In an interview on 10/31/24 at 10:38 AM, Certified Nurse Aide (CNA) HH reported Resident #27 had complained to her about not getting the foods that she ordered. CNA HH reported she had observed for herself that Resident #27, as well as other residents had not received the items on their meal trays that they have requested.</p> <p>During a lunch meal trayline observation in the kitchen on 10/30/24 beginning at 11:45 PM, Dietary Assistant (DA) BB was observed at the end of the trayline adding desserts and other cold items to the tray being assembled. Once assembled, DA BB put the meal tray into the meal delivery cart for delivery to resident. During the observation, at approximately 12:00 PM, this surveyor observed DA BB assemble a tray for a resident whose tray ticket included preferences for Magic Cup, 2 Cheeseburgers, and Pudding Daily. DA BB reached into the ice filled bin for pudding to add to the resident tray, was unable to locate pudding, and stated, there's no more pudding. DA BB then placed the tray into the meal delivery cart without any pudding. At approximately 12:12 PM, this surveyor notified Dietary Supervisor (DS) Z of the observation. DS Z confirmed with DA BB that the pudding had not been added to the resident tray because there's no more pudding. DS Z retrieved a can of pudding from the stock room, filled a cup with pudding, and sent it to the resident.</p> <p>Review of Resident Council Minutes for 9/27/24 revealed, New Business .wrong food .not following diets . pay attention to food preferences .</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46999</p> <p>Resident #78</p> <p>Review of an Admission Record revealed Resident #78, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia (chronic condition in which blood flow to the brain is reduced causing impaired thinking, memory, and behavior), feeding difficulties, and major depressive disorder (serious mental health condition causing persistent low mood and loss of interests).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #78, with a reference date of 09/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #78 was severely cognitively impaired. Section GG of the MDS revealed Resident #78 required supervision, verbal cueing and/or touching assistance for eating.</p> <p>Review of a Care Plan for Resident # 78, with a reference date of 10/5/22, revealed a problem/goal/approaches of: Problem: Alteration in ADLs (activity of daily living) .Goal: (Resident #78) will . participate in cares to her fullest ability. Approaches: Eating: Assist per 1 .offer resident choice in bathing, clothing, bedtime, etc.</p> <p>In an interview on 10/29/24 at 1:10pm, Family Member/Durable Power of Attorney (FM/DPOA) YY reported she assisted Resident #78 with eating everyday and had complained because Resident #78 did not consistently get her preferred drink (chocolate milk) on her meal tray. FM/DPOA YY reported when she spoke to the facility about Resident #78 not getting chocolate milk with her meals, the facility said they were having trouble getting chocolate milk delivered and did not have a solution for the problem.</p> <p>During an observation on 10/30/24 at 12:18pm, Resident #78 sat in the assisted dining room with her lunch in front of her on the table. A pale yellow beverage was present in a juice glass next to Resident #78's plate. No chocolate milk was observed.</p> <p>In an interview on 10/31/24 at 12:01pm, Certified Nursing Assistant (CNA) II reported she regularly assisted Resident #78 with eating. CNA II reported Resident #78's tray often arrived with no chocolate milk and when she followed up with the kitchen, she was told on several occasions there was no chocolate milk. CNA II reported the lack of chocolate milk was significant for Resident #78 because at times, that was the only thing she would accept at mealtime and would otherwise, not take in any nourishment. When further queried, CNA II reported she was aware of several residents who regularly did not receive chocolate milk at mealtime despite it being listed as their beverage of choice on their meal ticket.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982</p> <p>Based on observation and interview, the facility failed to: 1. Properly label/date and securely store food product once opened or prepared; 2. Discard expired food items; and 3. ensure cleanliness of food and non-food contact surfaces. These conditions resulted in an increased risk of contaminated foods and an increased risk of food borne illness that affected all residents who consume food/supplement from the kitchen and from nourishment room refrigerators/freezers.</p> <p>Findings include:</p> <p>An initial kitchen/food service tour was conducted on [DATE] beginning at 9:35 AM with Dietary Supervisor (DS) Z. The following observations were made:</p> <p>At 9:38 AM in the walk-in cooler: an opened, half empty container of nectar-thickened sweet tea with a manufacturer use by date of [DATE] and no label to indicate opened or discard dates; an opened bottle of nectar-thickened cranberry juice that was not labeled with opened or discard dates; and a pitcher of what DS Z reported was maple syrup that was not labeled for contents or opened or discard dates.</p> <p>At 9:45 AM in the reach-in cooler: two opened bottles of vegetable juice that were not labeled with opened or discard dates; and a storage container labeled apple juice with an opened date of ,d+[DATE] and a discard date of ,d+[DATE].</p> <p>At 9:53 AM, the plate warmer located by the trayline (the area in the kitchen where resident meal trays were assembled) was turned on to warm the plates. The top plate of one of the stacks of plates in the warmer had dried caked food debris on the edges. When DS Z removed that plate from the warmer to be rewashed, the plate underneath was noted to be soiled with food crumbs and debris. There was a divided dish stacked on the opposite stack of plates that had dried food debris in the wells of the plate.</p> <p>At 10:02 AM in the Birch nourishment room: In the refrigerator, there was an opened container of nectar-thickened water that was not labeled with opened or discard dates; 2 containers of resident food (unidentifiable) items that were unlabeled and undated; a Styrofoam container of resident food (spaghetti and meat sauce) that was dated with a single date of [DATE]. In the freezer, there was a fast-food restaurant name omitted red beverage that was frozen that was not labeled or dated.</p> <p>At 10:07 AM in the Dogwood nourishment room: In the refrigerator, there was an opened container of nutrition supplement drink labeled with an opened date of ,d+[DATE] and a discard date of ,d+[DATE]; there were three clear carafe containers filled with milk, orange juice, and lemonade that were not labeled with opened or discard dates; an opened, half empty container of nectar-thickened sweet tea that was not labeled with opened or discard dates; and an opened, half empty container of honey-thickened cranberry juice that was not labeled with opened or discard dates. There was dried red spillage in the refrigerator and freezer on the doors and there was dirt and debris behind and under the drawers in the refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 10:25 AM in the Evergreen nourishment room: In the refrigerator, there was a plastic grocery bag of resident food items that was not labeled or dated; two unlabeled sandwich bags of celery sticks that had become black at the ends and had areas of mold; an unlabeled, opened package of a log of cured snack meat, not securely covered and left opened to air, that was dried, shriveled, and black in color on the opened end; a bag of prepared tamales that was not labeled with prepared or discard dates; a scooped container of coleslaw that was not labeled with prepared or discard dates; an opened, three-fourths empty gallon of pasteurized apple cider that was not labeled with opened or discard dates; and an opened bottle of (brand name omitted) cream-based coffee drink that was not labeled with opened or discard dates. There was dried red spillage on the door of the refrigerator.</p> <p>In a follow-up interview on [DATE] at 11:26 AM, DS Z reported dietary staff were responsible for cleaning the nourishment room refrigerators and freezers. DS Z reported staff tried to clean them when they noticed they were dirty and then a deep scrub of the interior was done once a week. DS Z reported the expectation for food labeling and dating was that everything should be labeled and dated at the time it was opened, and resident food items should be labeled and dated by staff when they are brought in. DS Z reported opened drinks should be discarded after 5 days of being opened and prepared foods, including resident foods, should be discarded after 3 days from preparation.</p> <p>A follow-up kitchen/food service tour was conducted on [DATE] beginning at 11:30 AM with Dietary Assistant Supervisor (DAS) AA. The following observations were made:</p> <p>At 11:30 AM at the clean pan storage rack, noted 3 half pans that had been stacked together, on top of one another, such that the bottom of the stacked pan fit securely inside the next pan. When unstacked, it was noted that each of the pans was wet. DAS AA reported the pans should not have been put away wet because of the risk of bacterial growth.</p> <p>At 11:35 AM on the bottom shelf of a food preparation table, noted a stock pot that DAS AA reported as being clean and ready for use. Upon inspection, it was noted that the upper edge of interior of the pot had a small patch (the size of a dime) of caked, dried, granular substance that was yellowish in color. DAS AA reported it looked like dried powder from the dish machine and removed the pot to be rewashed.</p> <p>At 11:45 AM, the knife storage rack, on which 4 knives were being stored, was noted to be soiled with dust and debris on the top grates of the rack.</p> <p>During the follow-up kitchen/food service tour on [DATE], lunch meal service trayline that began at 11:45 AM was observed. During this observation, at approximately 11:52 AM, it was noted that Dietary [NAME] (DC) CC scooped a serving of gravy into a plastic (brand name omitted) bowl. There was what appeared to be a melted round ring around the interior of the bowl. This surveyor inquired to DC CC what the ring around the inside of the bowl was, to which DC CC reported it was just a stain from oatmeal and placed the bowl of gravy onto a resident meal tray which then went out to the care unit for delivery. DAS AA had stepped away momentarily and on her return, this surveyor queried her as to the process for damaged/stained dinnerware replacement. DAS AA reported when a staff member saw a bowl or other item that was in disrepair or stained, they were supposed to let her know to replace the item with a new one. DAS AA reported the facility had just gotten box of new bowls and the damaged/stained bowl should have been replaced and should not have been sent to a resident.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384</p> <p>Based on observation, interview, and record review, the facility failed to follow professional standards of infection control with resident's tube feeding equipment for one of one resident (R50) reviewed for infection control resulting in the potential for harborage and cross-contamination of pathogens in a vulnerable population.</p> <p>Findings include:</p> <p>Review of facility policy, Cleaning/Disinfecting Resident-Care Items reviewed 01/2024, revealed, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard .</p> <p>Review of facility policy, Tube Feeding reviewed 01/2024, revealed, To provide nutritionally complete tube or parenteral feedings as ordered by the physician or the nourishment of residents who are unable to eat normally .the nursing department is responsible for all feeding equipment .</p> <p>R50</p> <p>According to the Minimum Data Set (MDS) dated [DATE], R50 scored 10/15 (moderately cognitively intact) on her BIMS (Brief Interview Mental Status), required total assistance with ADLs (activities-of-daily-living) and diagnoses that included stroke.</p> <p>Review of R50's Order Summary dated 10/1/2024, revealed Osmolite 1.5 liquid; (tube feeding) . feeding tube (percutaneous endoscopic gastrostomy (PEG) tube feeding tube inserted through the abdomen into the stomach) Special Instructions .Every Shift NOC (night), AM (morning), PM (afternoon).</p> <p>Observed on 10/29/24 at 12:11 PM, R50's tube feeding, Osmolite 1.5, hung and running on a pole with pump at bedside. The tube feeding pole, base, pump, a 3-drawer plastic dresser (located next to pole), and radio (on dresser) had splatters of a dried substance resembling the hanging tube feeding.</p> <p>During an observation and interview on 10/31/24 at 10:38 AM of R50's tube feeding equipment with Licensed Practical Nurse (LPN) W, R50's tube feeding, Osmolite 1.5, hung and running on a pole with pump at bedside. The tube feeding pole, base, pump, a 3-drawer plastic dresser (located next to pole), and radio (on dresser) had splatters of a dried substance resembling the hanging tube feeding. The LPN stated, If the feeding splatters when staff connects or disconnects the feeding, it should be cleaned up right away for infection control purposes. The splatters get sticky and attracts dirt. I am not aware who is in charge of the cleaning of the equipment.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on interview and record review, the facility failed to ensure residents were screened for eligibility to receive Pneumococcal vaccinations and receive vaccination if eligible for 3 (Resident #18, #35 and #48) of 5 residents reviewed for vaccinations, resulting in the potential of acquiring, transmitting, or experiencing complications from pneumococcal pneumonia.</p> <p>Findings include:</p> <p>Resident #18</p> <p>Review of an Admission Record revealed Resident #18 was originally admitted to the facility on [DATE] with pertinent diagnoses which included weakness.</p> <p>Review of Resident #18's MCIR (Michigan Care Improvement Registry) revealed that Resident #18 had last received a Pneumococcal (Pnevnar13) vaccine on 12/13/2018.</p> <p>Review of Resident #18's Consent for Vaccinations form dated 10/2/23 indicated that Resident #18's legal guardian had consented for Resident #18 to receive the Pneumococcal vaccine.</p> <p>During an interview on 10/31/24 at 9:30 AM, Director of Nursing (DON) B confirmed that Resident #18 had last received a Pneumococcal vaccine in 2018. DON B was not able to provide verification that Resident #18 had been screened for eligibility and offered an updated Pneumococcal vaccine since his admission. DON B confirmed that Resident #18 was due for an updated Pneumococcal vaccine.</p> <p>Resident #35</p> <p>Review of an Admission Record revealed Resident #35 was originally admitted to the facility on [DATE] with pertinent diagnoses which included difficulty walking.</p> <p>Review of Resident #35's MCIR (Michigan Care Improvement Registry) revealed that Resident #35 had not received a Pneumococcal vaccine.</p> <p>Review of Resident #35's Vaccine Consent form dated 8/24/23 revealed that Resident #35 to receive the Pneumococcal vaccine.</p> <p>During an interview on 10/31/24 at 9:30 AM, DON B was not able to provide verification that Resident #35 had been screened for eligibility and offered Pneumococcal vaccine since her admission. DON B confirmed that Resident #35 was due for an updated Pneumococcal vaccine.</p> <p>Resident #48</p> <p>Review of an Admission Record revealed Resident #48 was originally admitted to the facility on [DATE] with pertinent diagnoses which included weakness.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #48's MCIR (Michigan Care Improvement Registry) revealed that Resident #48 had last received a Pneumococcal Prevnar 13 vaccine on 12/2/2015 and was due for an updated Pneumococcal vaccine.</p> <p>During an interview on 10/31/24 at 9:30 AM, DON B was not able to provide verification that</p> <p>Resident #48 had been screened for eligibility and offered a Pneumococcal vaccine since her admission. DON B reported that the nurse that admitted a new resident was responsible for screening for eligibility and then letting DON B know so that he could administer the vaccine. DON B confirmed that he was responsible for monitoring resident vaccines and ensuring that residents were offered and given vaccines when they were due, and that he had missed this.</p> <p>Review of the facility's Pneumococcal Vaccine Program policy last revised 9/2024 revealed, Policy:</p> <p>It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. Policy Explanation and Compliance Guidelines: 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER The Timbers of Cass County		STREET ADDRESS, CITY, STATE, ZIP CODE 55432 Colby St Dowagiac, MI 49047	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on interview and record review, the facility failed to ensure COVID-19 immunization were offered to 2 (Resident #18 and #48) out of 5 residents, reviewed for COVID-19 immunizations, resulting in the higher likelihood of infection and complications from COVID-19.</p> <p>Findings include:</p> <p>Resident #18</p> <p>Review of an Admission Record revealed Resident #18 was originally admitted to the facility on [DATE] with pertinent diagnoses which included weakness.</p> <p>Review of Resident #18's MCIR (Michigan Care Improvement Registry) revealed that Resident #18 had last received a Covid-19 immunization on 10/25/22.</p> <p>During an interview on 10/31/24 at 9:30 AM, Director of Nursing (DON) B reported that the facility was not screening and offering Covid-19 immunizations to residents that were eligible at admission or annually. DON B reported that he had been trying to coordinate a Covid-19 immunization clinic since June 2024, but he had gotten busy with other things and was not able to screen and offer Covid-19 immunizations to residents that were eligible and wanted to receive the vaccine. DON B was unable to provide verification that Resident #18 had been screened and offered the Covid-19 vaccine since his admission. DON B reported this was missed.</p> <p>Resident #48</p> <p>Review of an Admission Record revealed Resident #48 was originally admitted to the facility on [DATE] with pertinent diagnoses which included weakness.</p> <p>Review of Resident #48's MCIR (Michigan Care Improvement Registry) revealed that Resident #48 had last received a Covid-19 immunization on 9/20/2022.</p> <p>During an interview on 10/31/24 at 9:30 AM, Director of Nursing (DON) B was not able to provide verification that Resident #48 had been screened and offered the Covid-19 vaccine since her admission. DON B confirmed that this was missed.</p> <p>Review of the Facility's Covid-19 Vaccine Program Policy last revised 9/2024 revealed, Policy:</p> <p>It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine .1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>against COVID-19 disease in accordance with national standards of practice .10. COVID-19 vaccinations will be offered to residents when supplies are available, as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982</p> <p>Based on observation, interview, and record review, the facility failed to ensure clean and sanitary room and equipment conditions for 2 (Resident #27 and #55) of 20 sampled residents reviewed for sanitary conditions resulting in: 1.) a stained and soiled privacy curtain and dusty blinds for Resident #27, and 2.) a visibly soiled wheelchair for Resident #55.</p> <p>Findings include:</p> <p>Resident #27</p> <p>Review of an Admission Record revealed Resident #27 was a female, with pertinent diagnoses which included: secondary pulmonary arterial hypertension (high blood pressure that affects the arteries in the lungs), and type 2 diabetes mellitus (a condition where the body is not able to properly use sugar from the blood).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #27, with a reference date of 10/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #27 was cognitively intact.</p> <p>During an observation and interview on 10/29/24 at 11:36 AM, Resident #27 was in her room seated in her recliner chair watching television. The privacy curtain that separated Resident #27's section of the room and the entryway to the room was visibly soiled in multiple areas with dried brown and yellow streaks and stains. When queried as to how often the privacy curtain was changed or cleaned, Resident #27 stated, they never change it out. Resident #27 then directed this surveyor to observe the dust buildup present on the slats of the horizontal blinds on her window and reported they never dust those either. This surveyor confirmed a moderate amount of dust buildup on the slats of the blinds.</p> <p>In an observation on 10/30/24 at 2:56 PM, neither Resident #27's privacy curtain nor her window blinds had been cleaned.</p> <p>In an interview on 10/30/24 at 3:00 PM, Housekeeping/Laundry Aide ([NAME]) FF reported when cleaning a resident room, window blinds were to be dusted, and privacy curtains were supposed to be sprayed down and disinfected daily as part of the room clean. [NAME] FF reported if the privacy curtain appeared dirty or dingy, it should be taken down to laundry to be cleaned or replaced if in disrepair.</p> <p>In an interview on 10/30/24 at 3:04 PM, Housekeeping Supervisor (HS) EE reported the expectation for housekeepers when cleaning resident rooms was that the windowsills and blinds should be dusted if needed and the privacy curtains should be checked for cleanliness and wear and tear. HS EE reported if a curtain was dirty, the expectation was that it would be taken down and washed and replaced with a clean one.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Timbers of Cass County		STREET ADDRESS, CITY, STATE, ZIP CODE 55432 Colby St Dowagiac, MI 49047	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/30/24 at 3:08 PM, HS EE accompanied this surveyor to Resident #27's room. After obtaining permission to enter from Resident #27, HS EE observed the privacy curtain with this surveyor and confirmed that the privacy curtain should have been taken down and cleaned. HS EE observed the horizontal blind on Resident #27's window and confirmed it should have been dusted. HS EE confirmed both of those items should have been addressed over the last 24 hours because housekeeping was supposed to clean rooms daily.</p> <p>46999</p> <p>Resident #55</p> <p>Review of an Admission Record revealed Resident #55, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia (chronic condition in which blood flow to the brain is reduced causing impaired thinking, memory, and behavior), and cognitive communication deficit.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #55, with a reference date of 7/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated Resident #55 was unable to complete the assessment.</p> <p>During an observation on 10/29/24 at 10:50am, Resident #55 sat in her wheelchair in the common area of her unit. The frame of her wheelchair on both sides was visibly soiled with dried brown and white liquid. Dried crumbs were noted on the locking mechanisms and on the base of the leg rests. Dried white liquid was present on the foam support holding Resident #55's left calf.</p> <p>During an observation on 10/31/24 at 11:42am, Resident #55 sat in her wheelchair in the common area of her unit. The frame of her wheelchair remained thickly coated with dried white and brown liquid in large areas. Dried food crumbs were present on several flat areas of the chair and footrests.</p> <p>Using the reasonable person concept, though Resident #55 could not express her preferences, a reasonable person would likely experience discomfort because their equipment was heavily soiled by dried food crumbs and thickly coated with dried liquids.</p>		